



## Access to Coverage

January, 2008

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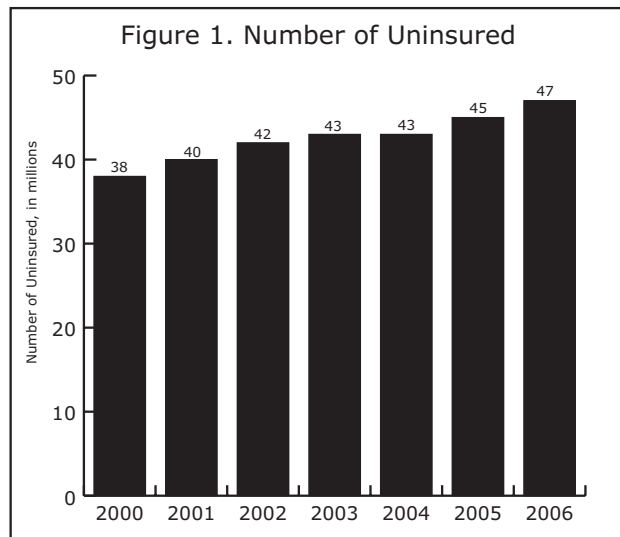
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### How many people are uninsured?

In 2006, 46.4 million Americans under age 65 (18 percent) were uninsured, according to the Census Bureau's 2007 Current Population Survey. The number and share of the population that is uninsured continues to climb. As shown in Figure 1, the number of Americans without coverage grew by more than 8.6 million between 2000 and 2006.

Most of those who have coverage obtain it through their jobs or from the public sector. The number of people who are covered in private—usually employer-sponsored programs—has declined, due in part to job loss and the rising costs of coverage. One disturbing trend is that a growing number of people who are offered coverage do not purchase it because it is too expensive. The working poor are especially likely to be uninsured because they find private coverage unaffordable, but they earn too much to be eligible for public benefits.

Meanwhile, the number of people who are



Source: The Commonwealth Fund; Data calculated from U.S. Census Bureau, March CPS Surveys 1988 to 2007.

covered in public programs has remained constant or grown slightly in recent years, although most state Medicaid and SCHIP programs, which expanded in the late 1990s, have slowed their enrollment growth. Between 2004 and 2005, the number of people with public coverage increased slightly, from 79.4 million to 80.2 million, but this growth reflected overall population expansion. The share of the population in these programs remained constant at 27.3 percent. <sup>1</sup>

## Why are people uninsured? What is the connection between employment and coverage?

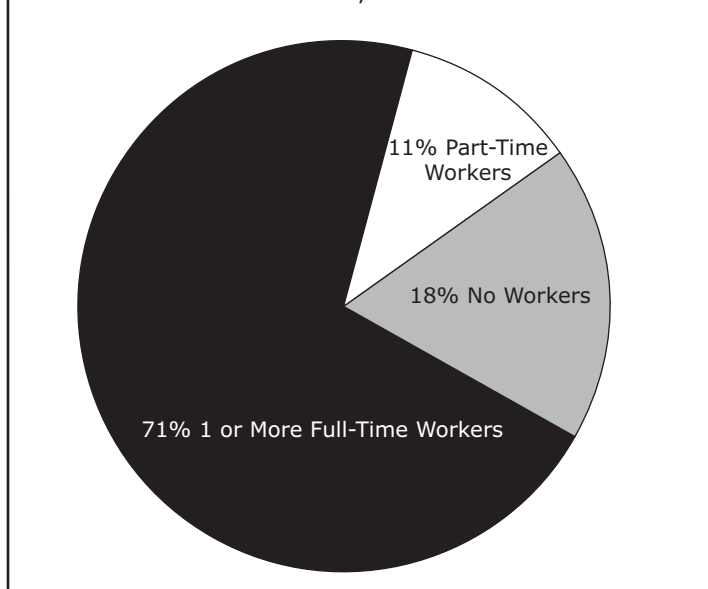
People are uninsured for many reasons: they cannot afford coverage (53.1 percent); they are ineligible for or do not want to enroll in public programs such as Medicaid; or they are not offered insurance at work (50 percent).<sup>1</sup>

Most of the uninsured either work or are in families headed by workers. Figure 2 illustrates the family work status among the uninsured. Those who work in smaller companies are less likely to be offered coverage than those who work in larger ones. Only 48 percent of firms with three to nine workers offered coverage in 2006, compared to 90 percent of firms with 50 or more workers. Service, domestic, agricultural and retail workers are particularly likely to be uninsured. Among self-employed adults, 28.9 percent were uninsured in 2005.

Overall, insured rates declined significantly from 2001 to 2005 for workers in all firms, regardless of size.<sup>2</sup>

Employees in low-wage companies are, on average, expected to pay a higher share of premiums than employees of higher-wage firms. On average, low-wage employees pay 35 percent of their premiums, while high-wage employees pay an average 26 percent.<sup>3</sup> Barely half of all poor workers—52.5 percent—were insured during 2002.<sup>4</sup> <sup>1</sup>

Figure 2. Characteristics of the Uninsured by Family Work Status, 2006

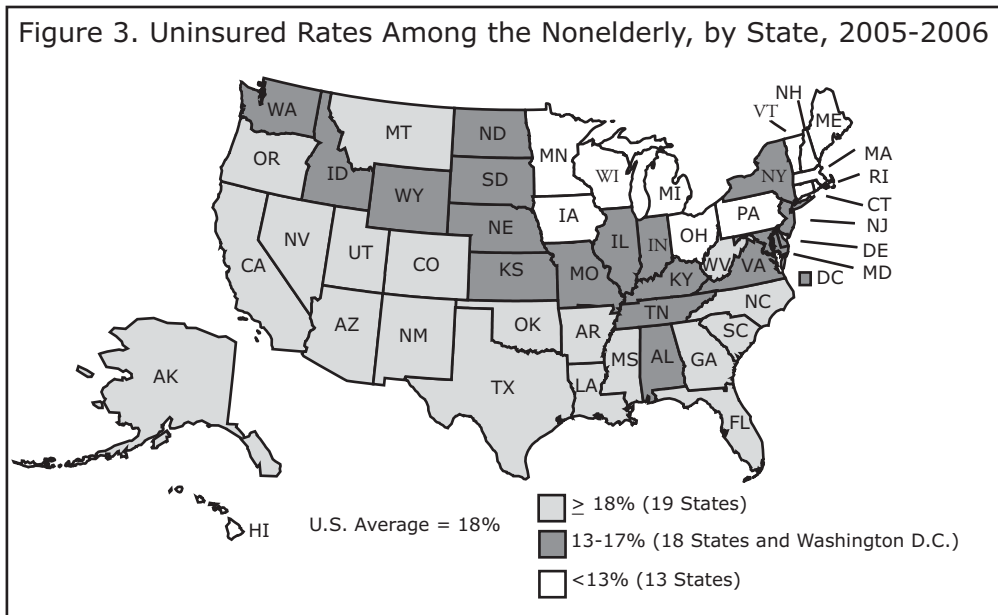


Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2007 CPS.

## Why is there so much difference from state to state in the number of uninsured people?

States differ widely in the number of uninsured. In 2006, according to the Current Population Survey, 18 percent or more of the population was uninsured in 19 states. Some of the highest rates are found in southwestern border states (Florida, New Mexico and Texas), where a relatively young, disproportionately uninsured Hispanic population may be a factor. Figure 3 displays the most recent CPS uninsured rates

among states.



The condition of a state's labor market clearly affects coverage. States in areas such as the Midwest, with historically industrialized and unionized workforces, tend to have high rates of employer-based coverage, while states in the Southeast, where wages historically have been lower and the workforce has been non-unionized, have less job-based coverage.

In the public sector, states cover low-income residents at varying income levels. Although Medicaid covered 40 percent of the poor in 2005, almost as many of the poor—37 percent of those below the poverty line—remained without coverage of any kind. <sup>46</sup>

## How are Medicaid and the State Children's Health Insurance Program (SCHIP) used as a base for other reforms?

Several states (Connecticut, Minnesota and Rhode Island) that have worked hard to expand coverage through their Medicaid programs can brag about the results. Three states known for distinctive and ambitious health reforms (Hawaii, Oregon and Tennessee) have below-average rates of uninsured but are closer to the mean. Other states with comparatively generous eligibility rules are swamped by the volume of need (California, New Mexico, New York and West Virginia). Several states that worked hard to enroll children in public programs (Minnesota, Missouri and Rhode Island) have made marked gains in coverage.

Public coverage interacts with employment in complicated ways. Concerns about "crowd-out"—the possibility that public coverage of children would supplant employer-based insurance—were voiced during debates over SCHIP. The converse seems to be at least as true, however: where workplace coverage is high, there is less need for public stop-gap measures to cover the uninsured.

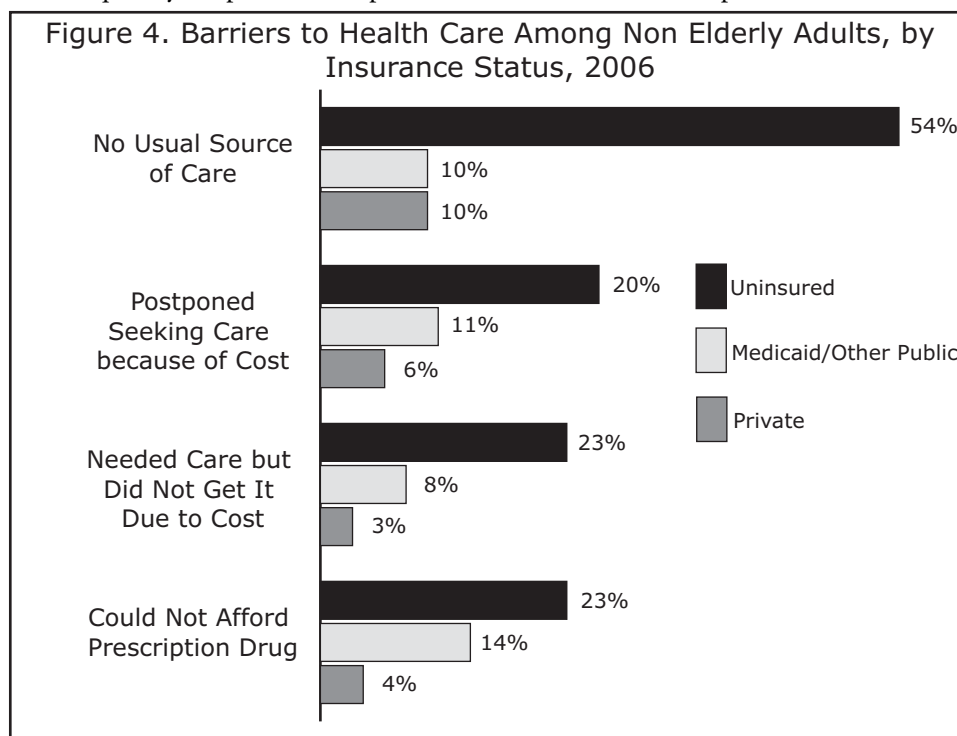
Some states have obtained waivers to use Medicaid and SCHIP funds to subsidize purchase of private health insurance. As of 2006, at least 15 states had established premium assistance programs to enable lower income individuals to obtain private coverage. Enrolling Medicaid-eligible individuals into private

insurance through premium assistance programs may minimize crowd-out concerns, but only limited evidence exists that these programs are effective in expanding coverage. <sup>4</sup>

## How does insurance affect people's health and well-being?

The uninsured receive less—and later—care because they often do not seek treatment until a disease or disorder has progressed. The delay often can have expensive and even fatal consequences. Figure 4 shows the disparities in barriers to health care among those with and without health insurance. Those with no health insurance are more frequently hospitalized for preventable conditions such as pneumonia and

uncontrolled diabetes, and cancer is likely to be diagnosed in later stages. Among the uninsured who have had cancer, 27 percent reported delaying care or deciding not to get treatment due to cost. After reviewing various studies, the Institute of Medicine's Committee on the Consequences of Uninsurance concluded that, overall, uninsured adults were 25 percent more likely to die than privately insured adults of the same age.<sup>5</sup>



Source: Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data, 2007.

Among children, ear infections (a common childhood illness that can lead to permanent hearing damage) go untreated 70 percent more often among uninsured children than among those who are covered. Uninsured children also are 30 percent less likely to receive medical care for injuries.

Although large portion of the uninsured are eligible for public coverage, they have not signed up. A federal rule requires Medicaid to provide three months of retroactive coverage to those who are eligible for coverage but are not enrolled. Some hospitals that provide emergency care are working to identify and enroll patients who owe a significant amount for care and who qualify for Medicaid, even if they are not enrolled in Medicaid when they are admitted.


Ironically, the uninsured may be charged more than those who have coverage. Health insurers typically negotiate with hospitals for lower prices, but uninsured patients may be obligated to pay the full bill. A recent study found that, in 2004, the rates hospitals charged many uninsured and other “self-pay” patients often were 2.5 times higher than the amount most health insurers paid on behalf of their beneficiaries.<sup>6</sup>

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## What is the safety net? Where do safety net institutions get their funding? Can anyone receive care if they go to a hospital?

The “safety net” refers to the patchwork of public hospitals, free clinics and community health centers that treat large populations of low-income, uninsured and other vulnerable patients. Safety net providers uphold, either through legal mandate or mission, an “open door” policy to accept all patients, regardless of their ability to pay for medical services.

These providers incur higher costs because they serve high levels of uninsured and Medicaid patients. Without nonpatient funding, such as state and federal subsidies, they risk insolvency. Hospitals that serve “disproportionately” high numbers of uninsured and Medicaid patients may qualify for enhanced Medicaid and Medicare payments. These institutions are known as disproportionate share hospitals (DSH, or “dish”).

Under federal law, all hospitals that receive federal funds and have emergency departments must “stabilize” patients who have a life-threatening crisis or are in active labor, regardless of whether they have coverage or funds. About 20 percent of all uninsured Americans consider the emergency room their usual source of care, compared to 3 percent for those with insurance.<sup>7</sup> 


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## What is the difference between an individual mandate and an employer mandate?

Individual and employer mandates are two methods that are being used to attempt to increase coverage. Individual mandates are laws that require each person to demonstrate that he or she has health coverage, either through purchase or by applying to a public program. In 2005, Massachusetts became the first state to enact a form of individual mandate. Individuals who fail to show they have purchased coverage are penalized through the tax system. The requirement is conditioned on availability of affordable coverage, and implementation of this reform has centered on definitions of affordable and adequate coverage.

Hawaii’s unique employer mandate requires employers to insure workers who work for more than 20 hours per week. The state enacted its mandate before 1974, when Congress passed the Employee Retirement Income Security Act (ERISA), the federal law that preempts state laws related to employer benefit plans.

ERISA has played an important role in state reforms. About 10 years ago, Massachusetts and Oregon enacted and subsequently repealed so-called “employer-pay-or-play” laws. These consisted of a payroll tax that was forgiven if employers covered their workers. Maryland enacted a similar law in 2006 that would have targeted the state’s largest employer, Wal-Mart. The courts struck down the law, ruling that it was preempted by ERISA.

Other states have passed similar pay-or-play laws but have yet to be confronted with an ERISA challenge. There may be a test soon, however. Although small employer levies are not central to access reforms in Vermont and Massachusetts, both states included them on certain employers based on their behavior in the health insurance market. 

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## Why do many reform proposals include so many provisions that have nothing to with access?

Access, quality and cost have been grouped together as the “three-legged stool” on which health reform rests. Unless all three are considered, changes in the system designed to improve one may adversely affect the others. For example, increasing access can raise costs or, if costs are held constant, lower the quality of the available product.

A basic assumption of health reform is that bringing people into the health system by providing insurance eventually reduces costs because care is provided before conditions progress to more serious and expensive stages. However, it is not always clear which health-care sector is saving and which is paying the savings into the overall system.

Maine experienced this when it attempted to recapture savings from its 2005 coverage expansions. Reformers assumed that increased coverage would lead to reduced hospital charges, and thus to lower insurance premiums. Lower volume harms rather than helps hospital profitability, however, producing higher charges elsewhere in the system. Maine’s access expansion bogged down in a dispute over whether savings were realized and who benefited from them.

Many reformers seek to improve quality and reduce costs by instituting wellness and disease management programs. More than 60 percent of health-care costs are attributed to spending on chronic conditions, and much of that is preventable or manageable. Prevention pays off—at least if targeted properly—but excessive screening can drive up costs if it leads to false positives and unnecessary follow-up tests. As with managed care, disease management may be designed to be little more than rate-setting and gatekeeping, or it may improve outcomes in particularly complex groups. Vermont has placed improving chronic care at the center of its reform effort.

Quality improvements—including the use of health information technology—are expected to save the system money over time, although in the short-term such improvements may require capital investments. Pennsylvania proposes reducing wasteful hospital infections, for example. Computerized prescription order entry and other electronic health recording systems, featured in the most recent health reform proposals, are expected to lower costs by preventing duplicative tests and reducing prescription errors. As with Maine’s access expansion, these improvements may lower overall costs, but the burden—largely on doctors—and benefit to the system are not evenly distributed. 

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## Have state reforms increased access to care and coverage?

No single answer has been discovered. The comprehensive state reform efforts that were proposed in the 1990s were never fully implemented, and incremental reform efforts have stalled recently in the face of daunting budgetary challenges. Nonetheless, state policymakers continue to look for a combination that will work.

A landmark law that will likely serve as an important template for future state reforms is the Massachusetts health-care plan, enacted in April 2006. The law’s individual mandate requires that residents obtain

coverage or face financial penalties. Residents who do not have an affordable option are exempt from the mandate. Employers with 11 or more workers who do not provide coverage will be assessed \$295 per employee. Employers can avoid the charge by offering IRS-approved section 125 plans, which allow workers to purchase health insurance with pre-tax dollars; employers do not need to pay premiums. The law also creates the Commonwealth Health Insurance Connector, a purchasing pool through which individuals and small businesses can obtain high-quality coverage. The Commonwealth Care Health Insurance Program provides subsidies based on a sliding scale for low-income people to purchase health insurance. Funding from the state's uncompensated care pool will be diverted to pay for the subsidies. The Massachusetts' SCHIP has been expanded to children up to 300 percent of poverty.

The Massachusetts plan has been in effect for one year and, according to the secretary of Health and Human Services' April 2007 report to the state legislature, about 110,000 individuals were enrolled under the plan during the year.

Illinois also has implemented a dramatic law. The Illinois All Kids Health Plan seeks to provide universal coverage to all resident children under age 18. Illinois' actions have been credited with sparking the movement to ensure health-care coverage for all children, and many other states (e.g., Pennsylvania, Tennessee and Oregon) have since followed suit with innovative plans to expand children's health care.

Signed by Governor Blagojevich in the fall of 2005, the Illinois law offers comprehensive coverage for all uninsured children, regardless of immigration status. The law is intended to capture uninsured children whose families earn too much to qualify for SCHIP. There are no income requirements or limits for eligibility, but monthly premiums and copayments are tied to family income.

The governor hoped to enroll 90,000 children during the first year at a cost of about \$81 million (\$44 million in state funds and \$37 million in federal funds).<sup>8</sup> To help fund the program, the governor proposed shifting Medicaid and Family Care beneficiaries to managed care.

It is difficult to measure the success of insurance reforms and expansions because so many changes to the health system occurred at the same time, but improvements to date seem modest. Even comparing states that do or do not implement a given policy change can be confusing, since it is not always possible to separate cause from effect. For example, some states that were experiencing rapidly disintegrating insurance markets passed particularly vigorous reforms. New York enacted a strict community rating law in the face of prospective insolvency and a 25 percent rate hike request from its carrier of last resort, Blue Cross. Was the deterioration in coverage that followed a result of the rating rule or was it due to the same conditions that led to the 25 percent rate hike? Conversely, states with low levels of uninsured have sometimes enacted bolder reforms because the potential costs are limited. Connecticut and Minnesota continue to build on past successes and a business climate that results in low levels of uninsured.

Local experiments—in locations as widespread as Hillsboro, Fla., Flint, Mich. and San Diego, Calif.—combine public and private funding streams and provider discounts to make an insurance product available to low-income or uninsured workers. These public-private partnerships or community partnerships take various forms and have not been successfully scaled to the state level. They have, however, attracted government and foundation interest. ■■■



## Notes

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*Other Sources*

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